MEDICAL DISPUTE RESOLUTION FINDINGS AND DECISION

PART I: GENERAL INFORMATION

Type of Requestor: (x) HCP ( ) IE ( ) IC	**Response Timely Filed?** (x) Yes ( ) No
Requestor's Name and Address Jacob Rosenstein, M.D. 800 W. Arbrook Blvd. #150 Arlington TX 76015	MDR Tracking No.: M4-03-7120-01 TWCC No.: Injured Employee's Name:
Respondent's Name and Address BOX #: 28 Arlington ISD c/o Liberty Mutual Ins. 2875 Browns Bridge Rd. Gainesville GA 30504	Date of Injury: Employer's Name: Arlington ISD Insurance Carrier's No.: 97000439

PART II: SUMMARY OF DISPUTE AND FINDINGS (Details on Page 2, if needed)

Dates of Service		**CPT Code(s) or Description**	**Amount in Dispute**	**Amount Due**
From	**To**			
2/4/03	**2/4/03**	**E0748**	**$1,000.00**	**$1,000.00**

PART III: REQUESTOR'S POSITION SUMMARY

6/12/03: "Enclosed please find copies of the note for the unit, invoice for the unit, request for reconsideration, HCFA, first and second explanation of benefits, and 3 other carrier's EOB's showing full payment for the same code…We billed fair and reasonable according to the TWCC MFG…"

PART IV: RESPONDENT'S POSITION SUMMARY

6/6/03: "We base our payments on the Texas Fee Guidelines and the TWCC Acts and Rules…Upon the original review…$3,995.00 was determined to be a fair and reasonable reimbursement for the same geographical area…appealed…The provider's invoice…revealed the actual cost…Liberty Mutual paid more than fair and reasonable…"

PART V: MEDICAL DISPUTE RESOLUTION REVIEW SUMMARY, METHODOLOGY, AND/OR EXPLANATION

CPT code E0748 for DOS 2/4/03 was denied 'F – The charge for this procedure exceeds the fee schedule or usual and customary values as established by Ingenix.' The requestor submitted convincing evidence of their usual and customary charges according to MFG/DME (IV) and 133.1(a)(8), therefore additional reimbursement of $1,000.00 is due ($4995.00 less paid $3995.00 = $1000.00).

PART VI: COMMISSION DECISION AND ORDER

Based upon the review of the disputed healthcare services, the Medical Review Division has determined that the requestor is entitled to additional reimbursement in the amount of $1,000.00. The Division hereby **ORDERS** the insurance carrier to remit this amount plus all accrued interest due at the time of payment to the Requestor within 20-days of receipt of this Order.

Ordered by:

	Carol Lawrence	3/29/05
Authorized Signature	Typed Name	Date of Order

PART VIII: YOUR RIGHT TO REQUEST A HEARING

Either party to this medical dispute may disagree with all or part of the Decision and has a right to request a hearing. A request for a hearing must be in writing and it must be received by the TWCC Chief Clerk of Proceedings/Appeals Clerk within 20 (twenty) days of your receipt of this decision (28 Texas Administrative Code § 148.3). This Decision was mailed to the health care provider and placed in the Austin Representatives box on _____. This Decision is deemed received by you five days after it was mailed and the first working day after the date the Decision was placed in the Austin Representative's box (28 Texas Administrative Code § 102.5(d)). A request for a hearing should be sent to: Chief Clerk of Proceedings/Appeals Clerk, P.O. Box 17787, Austin, Texas, 78744 or faxed to (512) 804-4011. A copy of this Decision should be attached to the request.

The party appealing the Division's Decision shall deliver a copy of their written request for a hearing to the opposing party involved in the dispute.

Si prefiere hablar con una persona in español acerca de ésta correspondencia, favor de llamar a 512-804-4812.

PART IX: INSURANCE CARRIER DELIVERY CERTIFICATION

I hereby verify that I received a copy of this Decision and Order in the Austin Representative's box.

Signature of Insurance Carrier: _____ Date: _____